HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

CARRIER

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, complete items 9, 9a, and 9d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

American Medical Center - Primary Care
Konrad-Adenauer Straße 4
66849 Landstuhl

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

TRICARE OVERSEAS PROGRAM

International SOS Assistance, Inc.

'Signature on File' Authorization Letter

The standard U.S. Government Claim Form CMS 1500 requires the patient's signature and the insured party's signature in order to be processed.

Note: The patient and the insured party will be the same person. Even if the patient is not the ADSM, the ADFM is considered the insured party.

Rather than the beneficiary having to sign the Claim Form every time a claim is submitted on his or her behalf, the provider can indicate on the CMS 1500 Claim Form that they hold a 'signature on file.' An actual signature is then no longer required.

The provider will need to collect the beneficiary's signature from the patient at the first appointment of each episode of care and keep it on record. The provider can then complete the Claim Form by writing 'Signature on File' or 'SOF' in the relevant field. We further recommend that the provider collect details of the patient's sponsor details at the same time. The provider will need these details when completing the CMS 1500 and UB-04 Claim Form.

Below is a sample 'Signature on File' form, which providers can ask beneficiaries to read and sign.

Institutions that are submitting a UB-04 Claim Form are required to have a permanent hospital record containing a release statement on behalf of the beneficiary. Institutions are encouraged to follow this procedure, to ensure compliance with TRICARE Overseas Program (TOP) 'Signature on File' requirements.

By signing this 'Signature on File' authorization letter, the beneficiary is validating all future claims submitted on their behalf. 'Signature on File' is not the preferred method of beneficiary consent. Whenever possible, an actual beneficiary signature (per claim) is the preferred method.

Dear Beneficiary,

By signing this statement, you are authorizing *(healthcare provider's name)* ____________________ to complete any necessary insurance Claim Forms on your behalf. You are hereby also authorizing the release of any medical or other information which may be needed in order to process said claims.

Your signature will be kept on file and shall be referred to when insurance Claim Forms are submitted for healthcare services you have received.

I consent to International SOS transferring my personal data outside the country in which care is provided, to and from my doctors in my country of origin, and to and from the doctors where I am currently being treated and to other territories that may protect my personal data in a legal manner differing from my country of origin or country in which care has been provided, including countries outside the European Economic Area (EEA).

Note: If the patient is incapable of signing or under the age of 18, a parent or legal guardian must sign in the patient's place. In such cases, the parent or legal guardian is considered the 'authorized person.'

Name of Patient: ____________________

Name of Legal Guardian or Parent (if applicable): ____________________

Signature: ____________________

Print Name: ____________________

Date: ____________________

Patient's Military Card ID number: ____________________

Sponsor's Name (ADSM): ____________________

Sponsor's Military Card ID number: ____________________

Europe, Middle East & Africa:
+44-20-8762-8384

Latin America & Canada:
+1-215-942-8393

Puerto Rico:
+1-877-867-1091

Asia-Pacific:
Singapore: +65-6339-2676
Sydney: +61-2-9273-2710